FOR OHF USE

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0022541

Facility Name: CONTINENTAL CARE CENTER

Address: 5336 N. WESTERN AVE (Number) CHICAGO (City) 60625 (Zip Code)

County: COOK

Telephone Number: (773) 271-5600 **Fax #** (773) 271-2144

IDPA ID Number: 362871756001

Date of Initial License for Current Owners: 00/0076

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) See Accountants' Compilation Report Attached (Date)
(Print Name and Title) MARVIN FOX, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	208	Skilled (SNF)	208	75,920	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	208	TOTALS	208	75,920	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	24,149	2,549	5,875	32,573	8
9	SNF/PED					9
10	ICF	19,234	200	51	19,485	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	43,383	2,749	5,926	52,058	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.57%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 07/01/76

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 32 and days of care provided 3,858

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	274,056	22,872	26,461	323,389		323,389	5,080	328,469			1
2	Food Purchase		246,389		246,389	(30,222)	216,167	(130)	216,037			2
3	Housekeeping	178,744	41,475		220,219		220,219		220,219			3
4	Laundry	77,745	27,514		105,259		105,259		105,259			4
5	Heat and Other Utilities			139,496	139,496		139,496	981	140,477			5
6	Maintenance	77,435		97,773	175,208		175,208	(20,353)	154,855			6
7	Other (specify):*							847	847			7
8	TOTAL General Services	607,980	338,250	263,730	1,209,960	(30,222)	1,179,738	(13,575)	1,166,163			8
	B. Health Care and Programs											
9	Medical Director			26,780	26,780		26,780		26,780			9
10	Nursing and Medical Records	1,986,590	195,564	427,760	2,609,914		2,609,914	(6,670)	2,603,244			10
10a	Therapy	103,334	811	8,894	113,039		113,039	(8,154)	104,885			10a
11	Activities	98,824	11,244	2,423	112,491		112,491		112,491			11
12	Social Services	95,090		3,494	98,584		98,584		98,584			12
13	Nurse Aide Training											13
14	Program Transportation			2,275	2,275		2,275		2,275			14
15	Other (specify):*							1,712	1,712			15
16	TOTAL Health Care and Programs	2,283,838	207,619	471,626	2,963,083		2,963,083	(13,112)	2,949,971			16
	C. General Administration											
17	Administrative	104,547		449,856	554,403		554,403	(194,655)	359,748			17
18	Directors Fees											18
19	Professional Services			121,794	121,794		121,794	(4,367)	117,427			19
20	Dues, Fees, Subscriptions & Promotions			90,193	90,193		90,193	(34,811)	55,382			20
21	Clerical & General Office Expenses	172,874	62,819	156,472	392,165		392,165	(85,264)	306,901			21
22	Employee Benefits & Payroll Taxes			571,424	571,424	30,222	601,646		601,646			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,392	10,392		10,392	(6,788)	3,604			24
25	Other Admin. Staff Transportation			3,508	3,508		3,508	(388)	3,120			25
26	Insurance-Prop.Liab.Malpractice			245,992	245,992		245,992	1,144	247,136			26
27	Other (specify):*							16,575	16,575			27
28	TOTAL General Administration	277,421	62,819	1,649,631	1,989,871	30,222	2,020,093	(308,554)	1,711,539			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,169,239	608,688	2,384,987	6,162,914		6,162,914	(335,241)	5,827,673			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number CONTINENTAL CARE CENTER #0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			162,777	162,777		162,777	10,496	173,273			30
31	Amortization of Pre-Op. & Org.			14,304	14,304		14,304		14,304			31
32	Interest			317,180	317,180		317,180	(194,699)	122,481			32
33	Real Estate Taxes			264,911	264,911		264,911		264,911			33
34	Rent-Facility & Grounds							8,407	8,407			34
35	Rent-Equipment & Vehicles			10,289	10,289		10,289	461	10,750			35
36	Other (specify):*											36
37	**TOTAL Ownership**			769,461	769,461		769,461	(175,335)	594,126			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	208,028	413,974	678,604	1,300,606		1,300,606	(2,725)	1,297,881			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			113,890	113,890		113,890	(10)	113,880			42
43	Other (specify):*	41,869		19,150	61,019		61,019	(61,019)	(0)			43
44	**TOTAL Special Cost Centers**	249,897	413,974	811,644	1,475,515		1,475,515	(63,754)	1,411,761			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,419,136	1,022,662	3,966,092	8,407,890		8,407,890	(574,331)	7,833,559			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	239	30		9
10	Interest and Other Investment Income	(196,697)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(130)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(447)	21		18
19	Entertainment	(6,543)	24		19
20	Contributions	(4,468)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(105,000)	21		24
25	Fund Raising, Advertising and Promotional	(31,785)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(211)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(2,518)	20		28
29	Other-Attach Schedule	(101,401)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (448,961)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(125,370)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (125,370)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (574,331)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS
CONTINENTAL CARE CENTER

ID# 0022541
Report Period Beginning: 01/01/02
Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	IL COUNCIL ON LTC - COPE	$ (4,107)	20	1
2	BED TAX - OVER-ACCRUAL	(18)	42	2
3	MARKETING SALARIES	(41,869)	43	3
4	VA PHARMACY	(2,312)	10	4
5	COLLECTIONS (DOCUMENTATION SOLUTIONS)	(175)	19	5
6	MARKETING CONSULTANT	(2,931)	43	6
7	BANK CHARGES	(14,000)	21	7
8	OUT OF STATE TRAVEL	(366)	25	8
9	UNDOCUMENTED SEMINARS	(605)	24	9
10	OUT OF STATE SEMINAR	(375)	24	10
11	CAPITALIZED R&M	(21,169)	06	11
12	OUT OF PERIOD LEGAL	(7,977)	19	12
13	UNDOCUMENTED LEGAL	(3,059)	19	13
14	PRIOR PERIOD AUTO EXPENSE	(38)	25	14
15	MARKETING TRAVEL EXPENSE	(2,406)	43	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
51				51
52				52
53				53
54				54
55				55
56				56
57				57
58				58
59				59
60				60
61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90				90
91				91
92				92
93				93
94				94
95				95
96				96
97				97
98				98
99				99
100				100
101	Total	(101,401)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				5,225		(145)						5,080	1
2	Food Purchase	(130)											(130)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities					981							981	5
6	Maintenance	(21,169)				318	498						(20,353)	6
7	Other (specify):*						847						847	7
8	**TOTAL General Services**	(21,299)			5,225	1,299	1,200						(13,575)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(2,312)			(16,659)	12,301							(6,670)	10
10a	Therapy			96			(8,250)						(8,154)	10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*					1,712							1,712	15
16	**TOTAL Health Care and Programs**	(2,312)		96	(16,659)	14,013	(8,250)						(13,112)	16
	C. General Administration													
17	Administrative					59,688		(254,343)					(194,655)	17
18	Directors Fees													18
19	Professional Services	(11,211)				6,108	(179,839)	180,575					(4,367)	19
20	Fees, Subscriptions & Promotions	(38,410)				3,570		29					(34,811)	20
21	Clerical & General Office Expenses	(124,126)				65,141		(26,279)					(85,264)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(7,523)				735							(6,788)	24
25	Other Admin. Staff Transportation	(404)				16							(388)	25
26	Insurance-Prop.Liab.Malpractice					1,201		(57)					1,144	26
27	Other (specify):*					15,411		1,164					16,575	27
28	**TOTAL General Administration**	(181,674)				151,870	(179,839)	(98,911)					(308,554)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(205,285)		96	(11,434)	167,182	(186,889)	(98,911)					(335,241)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	239				3,329		6,928					10,496	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(196,697)				894		1,104					(194,699)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds					8,407							8,407	34
35	Rent-Equipment & Vehicles						461						461	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(196,458)				12,630	461	8,032					(175,335)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers			9,271	(11,996)								(2,725)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee	(10)											(10)	42
43	Other (specify):*	(47,207)					(13,812)						(61,019)	43
44	**TOTAL Special Cost Centers**	(47,217)		9,271	(11,996)		(13,812)						(63,754)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(448,961)		9,367	(23,430)	179,812	(200,240)	(90,879)					(574,331)	45

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached		See attached		See attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	REHAB CONSULTING	$ 6,604	Advanced Therapy and Rehab, LLC	100.00%	$ 6,700	$ 96	15
16	V	39	ANCILLARY REHAB	634,968	Advanced Therapy and Rehab, LLC	100.00%	644,239	9,271	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 641,572			$ 650,939	$ * 9,367	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	MEDICAL/TUBE FEED-MDCR	$ 19,828	QUALITY CARE MEDICAL SUPPLY	100.00%	$ 7,832	$ (11,996)	15
16	V	10	MEDICAL SUPPLIES	18,898	QUALITY CARE MEDICAL SUPPLY	100.00%	2,239	(16,659)	16
17	V	1	FOOD SUPPLEMENTS		QUALITY CARE MEDICAL SUPPLY	100.00%	5,225	5,225	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 38,726			$ 15,296	$ * (23,430)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	$ 981	$ 981	15
16	V	6	REPAIRS AND MAINT.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	318	318	16
17	V	10	NURSING		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	5,007	5,007	17
18	V	10	SAL-NURSING-M. DEAL		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	7,294	7,294	18
19	V	15	EMP. BEN.-H.C.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	1,712	1,712	19
20	V	17	ADMIN SAL-NON-OWNER		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	4,042	4,042	20
21	V	17	ADMIN. SAL.- F. BENJAMIN		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	12,577	12,577	21
22	V	17	ADMIN. SAL - B BENOUDIZ		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	4,906	4,906	22
23	V	17	ADMIN. SAL. - B. CLOCH		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	10,862	10,862	23
24	V	17	ADMIN. SAL. - C. ROSS		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	6,412	6,412	24
25	V	17	ADMIN. SAL - S. VAN CAMP		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	8,418	8,418	25
26	V	17	ADMIN. SAL. - M. FILIPPO		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	10,496	10,496	26
27	V	17	ADMIN. SAL. - J. ELOWE		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	1,975	1,975	27
28	V	19	PROFESSIONAL FEES		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	6,108	6,108	28
29	V	20	FEES,SUBSCRIPTIONS		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	3,570	3,570	29
30	V	21	CLERICAL & GENERAL		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	62,233	62,233	30
31	V	21	SALARIES-ACCTG-B. LARIMORE		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	2,908	2,908	31
32	V	24	EDUCATION & SEMINAR		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	735	735	32
33	V	25	OTHER ADMIN. STAFF TRANS.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	16	16	33
34	V	26	INSURANCE		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	1,201	1,201	34
35	V	27	EMP. BEN.-GEN. ADMIN.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	15,411	15,411	35
36	V	30	DEPRECIATION		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	3,329	3,329	36
37	V	32	INTEREST		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	894	894	37
38	V	34	OFFICE RENT-UNRELATED		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	8,407	8,407	38
39	Total			$			$ 179,812	$ * 179,812	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	EQUIPMENT RENTAL		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	461	$ 461	15
16	V	19	CORP ALLOC/MGMT FEE	179,839	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	$	(179,839)	16
17	V	6	REPAIRS AND MAINT.	3,016	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	3,514	498	17
18	V	7	EMP. BEN.-GEN. SERV.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	474	474	18
19	V	10	NURSE CONSULTANT		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%			19
20	V	1	DIETICIAN SALARIES	2,910	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	2,765	(145)	20
21	V	7	EMP. BEN.-GEN. ADMIN.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	373	373	21
22	V	10A	RESPIRATORY THERAPIST	8,250	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%		(8,250)	22
23	V	43	MARKETING CONSULTANT	13,812	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%		(13,812)	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 207,827			$ 7,587	$ * (200,240)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	26	INSURANCE	$	QUALITY CARE MANAGEMENT	100.00%	$ (57)	$ (57)	15
16	V	17	ADMIN. SAL. - B. CLOCH		QUALITY CARE MANAGEMENT	100.00%	4,756	4,756	16
17	V	17	ADMIN. SAL. - B. TEITELBAUM		QUALITY CARE MANAGEMENT	100.00%	3,370	3,370	17
18	V	17	ADMIN. SAL - J. MEISELS		QUALITY CARE MANAGEMENT	100.00%	1,387	1,387	18
19	V	19	PROFESSIONAL FEES		QUALITY CARE MANAGEMENT	100.00%	736	736	19
20	V	19	MGNT FEES-DIRECT ALLOC		QUALITY CARE MANAGEMENT	100.00%	179,839	179,839	20
21	V	20	FEES,SUBSCRIPTIONS		QUALITY CARE MANAGEMENT	100.00%	29	29	21
22	V	21	CLERICAL & GENERAL		QUALITY CARE MANAGEMENT	100.00%	(2,279)	(2,279)	22
23	V	27	EMP. BEN.-GEN. ADMIN.		QUALITY CARE MANAGEMENT	100.00%	1,164	1,164	23
24	V	30	DEPRECIATION		QUALITY CARE MANAGEMENT	100.00%	6,928	6,928	24
25	V	32	INTEREST		QUALITY CARE MANAGEMENT	100.00%	1,104	1,104	25
26	V								26
27	V								27
28	V	17	CORPORATE ALLOCATION	263,856	QUALITY CARE MANAGEMENT	100.00%		(263,856)	28
29	V	21	COMPUTER SERVICES	24,000	QUALITY CARE MANAGEMENT	100.00%		(24,000)	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 287,856			$ 196,977	$ * (90,879)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	David Meisels	Exec Administrator	Administrative	20.00%	See attached	7.5	13.64%	Mgmt fees	$ 65,000	17-3	1
2	Brucha Teitelbaum	Owner	Administrative	2.00%	See attached	0.72	1.80%	Alloc Salary	3,370	17-7	2
3	Joseph Meisels	Owner	Administrative	2.00%	See attached	2.89	5.78%	Alloc Salary	1,387	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 69,757		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ADVANCED THERAPY AND REHAB, LLC
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847)663-1155
Fax Number: (847)663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10A	REHAB CONSULTING	DIRECT ALLOCATION						6,700	1
2	39	ANCILLARY REHAB	DIRECT ALLOCATION						644,239	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 650,939	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: QUALITY CARE MEDICAL SUPPLY
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847)663-1155
Fax Number: (847)663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	MEDICAL/TUBE FEED-MDCR	DIRECT ALLOCATION						7,832	1
2	10	MEDICAL SUPPLIES	DIRECT ALLOCATION						2,239	2
3	1	FOOD SUPPLEMENTS	DIRECT ALLOCATION						5,225	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 15,296	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: BOULEVARD HEALTHCARE MANAGEMEN
Street Address: 8950 GROSS POINT RD. SUITE 600
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	404,328	8	$ 18,054	$	21,959	$ 981	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	404,328	8	5,848		21,959	318	2
3	10	NURSING	PATIENT DAYS	404,328	8	92,189	90,660	21,959	5,007	3
4	10	SAL-NURSING-M. DEAL	PATIENT DAYS	404,328	8	134,295	134,295	21,959	7,294	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	404,328	8	31,517		21,959	1,712	5
6	17	ADMIN SAL-NON-OWNER	PATIENT DAYS	404,328	8	74,422	74,422	21,959	4,042	6
7	17	ADMIN. SAL.- F. BENJAMIN	PATIENT DAYS	404,328	8	231,575	231,575	21,959	12,577	7
8	17	ADMIN. SAL - B BENOUDIZ	PATIENT DAYS	404,328	8	90,333	90,333	21,959	4,906	8
9	17	ADMIN. SAL. - B. CLOCH	PATIENT DAYS	404,328	8	200,000	200,000	21,959	10,862	9
10	17	ADMIN. SAL. - C. ROSS	PATIENT DAYS	404,328	8	118,071	118,071	21,959	6,412	10
11	17	ADMIN. SAL - S. VAN CAMP	PATIENT DAYS	404,328	8	155,000	155,000	21,959	8,418	11
12	17	ADMIN. SAL. - M. FILIPPO	PATIENT DAYS	404,328	8	193,262	193,262	21,959	10,496	12
13	17	ADMIN. SAL. - J. ELOWE	PATIENT DAYS	404,328	8	36,364	36,364	21,959	1,975	13
14	19	PROFESSIONAL FEES	PATIENT DAYS	404,328	8	112,461		21,959	6,108	14
15	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	404,328	8	65,740		21,959	3,570	15
16	21	CLERICAL & GENERAL	PATIENT DAYS	404,328	8	1,145,893	1,000,220	21,959	62,233	16
17	21	SALARIES-ACCTG-B. LARIMO	PATIENT DAYS	404,328	8	53,541	53,541	21,959	2,908	17
18	24	EDUCATION & SEMINAR	PATIENT DAYS	404,328	8	13,535		21,959	735	18
19	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	404,328	8	300		21,959	16	19
20	26	INSURANCE	PATIENT DAYS	404,328	8	22,107		21,959	1,201	20
21	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	404,328	8	283,762		21,959	15,411	21
22	30	DEPRECIATION	PATIENT DAYS	404,328	8	61,299		21,959	3,329	22
23	32	INTEREST	PATIENT DAYS	404,328	8	16,452		21,959	894	23
24	34	OFFICE RENT-UNRELATED	PATIENT DAYS	404,328	8	154,799		21,959	8,407	24
25	TOTALS					$ 3,310,819	$ 2,377,744		$ 179,812	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: BOULEVARD HEALTHCARE MANAGEMEN
Street Address: 8950 GROSS POINT RD. SUITE 600
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	35	EQUIPMENT RENTAL	PATIENT DAYS	404,328	8	8,483		21,959	461	1
2										2
3	6	REPAIRS AND MAINT.	PAINTING REVENUE	12,688	2	14,784	14,784	3,016	3,514	3
4	7	EMP. BEN.-GEN. SERV.	PAINTING REVENUE	12,688	2	1,994		3,016	474	4
5						$	$			5
6	1	DIETICIAN SALARIES	DIETICIAN REVENUE	41,225	8	39,169	39,169	2,910	2,765	6
7	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN REVENUE	41,225	8	5,282		2,910	373	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 69,712	$ 53,953		$ 7,587	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: QUALITY CARE MANAGEMENT
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	26	INSURANCE	PATIENT DAYS	152,042	5	$ (394)	$ (394)	21,959	$ (57)	1
2	17	ADMIN. SAL. - B. CLOCH	PATIENT DAYS	152,042	5	32,933	32,933	21,959	4,756	2
3	17	ADMIN. SAL. - B. TEITELBAUM	PATIENT DAYS	152,042	5	23,333	23,333	21,959	3,370	3
4	17	ADMIN. SAL - J. MEISELS	PATIENT DAYS	152,042	5	9,600	9,600	21,959	1,387	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	152,042	5	5,097		21,959	736	5
6	19	MGNT FEES-DIRECT ALLOC	DIRECT ALLOCATION		5	857,602			179,839	6
7	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	152,042	5	200		21,959	29	7
8	21	CLERICAL & GENERAL	PATIENT DAYS	152,042	5	(15,781)		21,959	(2,279)	8
9	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	152,042	5	8,058		21,959	1,164	9
10	30	DEPRECIATION	PATIENT DAYS	152,042	5	47,971		21,959	6,928	10
11	32	INTEREST	PATIENT DAYS	152,042	5	7,643		21,959	1,104	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 976,262	$ 65,472		$ 196,977	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	American Charter Bank		X	Martgage	Varies	10/27/01	$ 3,650,000	$ 3,396,369	01/01/07	Prime+1.5	$ 194,356	1
2												2
3												3
4												4
5	Viasys/Bird		X	Equipment Purchase	$2,006.00	05/09/01		70,477	04/09/06		8,574	5
	Working Capital											
6	Bank Leumi		X	Line of Credit							2	6
7	Universal		X	Insurance							11,573	7
8	DVI		X	Line of Credit	Interest Only	10/15/01		800,651	Demand		102,675	8
9	TOTAL Facility Related				$2,006.00		$ 3,650,000	$ 4,267,497			$ 317,180	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										1,998	10
11	Interest Income										(196,697)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (194,699)	14
15	TOTALS (line 9+line14)						$ 3,650,000	$ 4,267,497			$ 122,480	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Alloc from Boulevard Healthcare	X					$	$			$ 894	1
2	Alloc from Quality Care	X									1,104	2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ 1,998	21

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	260,700	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	257,211	2
3. Under or (over) accrual (line 2 minus line 1).	$	(3,489)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	268,400	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	264,911	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997	265,995	8
1998	248,551	9
1999	246,883	10
2000	250,691	11
2001	257,211	12

2002 ACCRUAL 257,211 X 1.04 = 268,400

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CONTINENTAL CARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0022541

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-12-226-006	Long term care property	$ 222,596.63	$ 222,596.63
2.	13-12-226-007	Long term care property	$ 30,177.56	$ 30,177.56
3.	13-12-226-018	Long term care property	$ 4,436.98	$ 4,436.98
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 257,211.17	$ 257,211.17

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CONTINENTAL CARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0022541

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE ( ) _____ FAX #: ( ) _____

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 54,288 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 4

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 31,265
2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: 14,304
4. Dates Incurred: _____

Nature of Costs: LOC and Finance fees
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	108,000	1976	$ 356,000	1
2					2
3	TOTALS	108,000		$ 356,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4				1976	$ 2,130,000	$ 60,879	35	$ 60,857	$ (22)	$ 1,369,264	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1979	6,105		20	-		6,105	9
10	Various			1980	9,032		20	-		9,032	10
11	Various			1983	19,029		20	-		19,029	11
12	Various			1985	24,698		20	985	985	19,674	12
13	Various			1986	43,755		20	2,188	2,188	31,065	13
14	Various			1987	31,019		20	245	245	29,421	14
15	Various			1988	12,294		20	137	137	11,312	15
16	Various			1989	27,060		20	985	985	19,274	16
17	Various			1991	19,303		20	965	965	11,004	17
18	Various			1992	2,934		20	147	147	2,931	18
19	Various			1993	11,866		20	594	594	5,800	19
20	Various			1994	38,563		20	2,094	2,094	17,660	20
21	Various			1995	54,419		20	2,721	2,721	21,780	21
22	Various			1996	65,777		20	2,962	2,962	19,086	22
23	Various			1997	16,158		20	808	808	4,316	23
24	Various			1998	180,933		20	9,047	9,047	40,385	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		5,304	672		672		672	68
69	Financial Statement Depreciation			33,927			(33,927)		69
70	TOTAL (lines 4 thru 69)		$ 2,698,249	$ 95,478		$ 85,407	$ (10,071)	$ 1,637,810	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,698,249	$ 95,478		$ 85,407	$ (10,071)	$ 1,637,810	1
2	CARPET & INSTALL	1999	2,088		20	104	104	399	2
3	FIRE DAMPERS	1999	29,600		20	1,480	1,480	5,673	3
4	INSULATION BOILER	1999	1,297		20	65	65	249	4
5	INSTALL FLOORING	1999	1,847		20	92	92	330	5
6	INFRARED DOOR DETECT	1999	4,300		20	215	215	770	6
7	THEROTECH	1999	2,657		20	133	133	466	7
8	INST.FUEL TANK 50%	1999	4,293		20	215	215	681	8
9	DOOR ALARMS	1999	2,273		20	114	114	447	9
10	PAINTING & DECORATIN	1999	7,683		20	384	384	1,344	10
11	HVAC-MOTOR & DISCONN	1999	808		20	40	40	153	11
12	EXPLOSION PROOF BRAC	1999	1,072		20	54	54	203	12
13	COOLING TOWER BEARIN	1999	1,575		20	79	79	296	13
14	INSTALL DOOR CLOSER	1999	610		20	31	31	116	14
15	REPLACE CONN.OVEN DO	1999	1,245		20	62	62	233	15
16	B & G BEARING ASSEMB	1999	698		20	35	35	128	16
17	REPAIR COOLING TOWER	1999	1,165		20	58	58	213	17
18	REPLACE H20 PUMPSEAL	1999	576		20	29	29	106	18
19	REPAIR FIRE ALARM SY	1999	870		20	44	44	161	19
20	EJECTOR PUMP PARTS	1999	1,546		20	77	77	276	20
21	REPAIR NURSE CALL SY	1999	843		20	42	42	151	21
22	INSTALL LIGHTS IN OX	1999	920		20	46	46	161	22
23	MOTORIZED DAMPER	1999	1,498		20	75	75	256	23
24	PATIO DOOR TEMPERED	1999	513		20	26	26	89	24
25	DOOR HINGE & REINFOR	1999	727		20	36	36	117	25
26	INSTALL HVAC PIPING	1999	550		20	28	28	91	26
27	INSTALL DOOR HINGE	1999	2,730		20	137	137	434	27
28	INSTALL SPRINKLER	1999	735		20	37	37	117	28
29	REPAIR CALL SYST	1999	1,528		20	76	76	298	29
30	LOCKS	1999	1,681		20	84	84	329	30
31	LANDING GATES&HANDRA	1999	978		20	49	49	196	31
32	SATELLITE SYSTEM	2000	40,000		20	6,997	6,997	22,508	32
33	FIRE DAMPERS	2000	31,000		20	795	795	2,352	33
34	TOTAL (lines 1 thru 33)		$ 2,848,155	$ 95,478		$ 97,146	$ 1,668	$ 1,677,153	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,848,155	$ 95,478		$ 97,146	$ 1,668	$ 1,677,153	1
2	ELECTRICAL WIRING	2000	6,272		20	161	161	476	2
3	25 DOORS	2000	3,942		20	757	757	2,807	3
4	ELECTRIC WIRING	2000	798		20	20	20	58	4
5	II ACCESS DOORS	2000	1,986		20	381	381	1,414	5
6	ELECTRIC WIRING	2000	1,695		20	43	43	109	6
7	FENCE	2000	511		20	44	44	119	7
8	INSTALL BREAKER	2000	2,832		20	73	73	179	8
9	FIRE GUARD TANK	2000	6,381		20	164	164	417	9
10	PUSH BUTTON LOCKS	2000	583		20	112	112	415	10
11	ELECTRIC WIRING	2000	12,475		20	320	320	733	11
12	ELECTRIC TRANSFER	2000	11,246		20	288	288	636	12
13	FUEL TANK	2000	2,462		20	164	164	435	13
14	INSTALL MIRROR	2000	1,957		20	376	376	1,394	14
15	REHAB ROOM	2000	1,392		20	36	36	80	15
16	ELECTRIC REHAB ROOM	2000	1,650		20	42	42	89	16
17	WIRING KITCHEN	2000	769		20	20	20	43	17
18	INSTALL PHONES	2000	743		20	37	37	74	18
19	PAINTING & DECORATIN	2000	1,284		20	64	64	128	19
20	BLINDS	2000	662		20	33	33	66	20
21	BOILER HEAT EXCHNG	2000	4,950		20	248	248	496	21
22	REPLACE SPRINKLER SY	2001	825		20	41	41	82	22
23	FIRE ALARM PANEL	2001	995		20	50	50	100	23
24	PLUMBING	2001	778		20	39	39	78	24
25	INSTALL PHONE LINES	2001	1,171		20	59	59	108	25
26	EXHAUST SYSTEM	2001	2,500		20	125	125	229	26
27	ELECTRICAL OUTLETS	2001	775		20	39	39	68	27
28	FIRE DOORS INST.	2001	970		20	49	49	82	28
29	HEAT EXCHANGER	2001	4,950		20	248	248	413	29
30	BOILER PIPE INST.	2001	1,120		20	56	56	93	30
31	CHAIN LINK FENCE	2001	988		20	49	49	82	31
32	FIRE DAMPERS INSTALL	2001	2,908		20	145	145	218	32
33	REWIRE PUMP MOTOR	2001	1,598		20	80	80	87	33
34	TOTAL (lines 1 thru 33)		$ 2,932,323	$ 95,478		$ 101,509	$ 6,031	$ 1,688,961	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,932,323	$ 95,478		$ 101,509	$ 6,031	$ 1,688,961	1
2	REPLACE EXHAUST MOTO	2001	1,087		20	54	54	59	2
3	ELECTRICAL WIRING	2001	1,496		20	75	75	81	3
4	ROOFTOP EXHAUST	2001	609		20	30	30	45	4
5	REFRIGERATOR WORK	2001	508		20	25	25	35	5
6	WROUGHT IRON FENCE	2001	980		20	49	49	74	6
7	EJECTOR PUMP PARTS	2001	1,968		20	98	98	139	7
8	FIRE ALARM PARTS	2001	513		20	26	26	35	8
9	LIFE ALARM	2001	1,962		20	98	98	139	9
10	VALVE WORK	2001	909		20	45	45	53	10
11	CUSTOM DRAPERIES	2001	1,919		20	96	96	104	11
12	LIFE ALARM KEYBOARD	2001	1,394		20	70	70	76	12
13	INSTALL TELEPHONE WIRING	2002	3,435		20	229	229	229	13
14	REMOVE AND REPLACE COOLING TOWER	2002	17,900		20	1,193	1,193	1,193	14
15	INSTALL DUCT WORK/ FIRE DAMPERS	2002	650		20	43	43	43	15
16	REMOVE AND INSTALL CARPET	2002	16,641		20	1,585	1,585	1,585	16
17	INSTALL INTERCOM SYSTEM	2002	800		20	76	76	76	17
18	CONCRETE WORK TO REPAIR PARKING LOT	2002	4,435		20	203	203	203	18
19	INSTALL DUCT DETECTORS PER IDPH REPORT	2002	9,450		20	236	236	236	19
20	CONCRETE WORK TO REPAIR PARKING LOT	2002	4,025		20	50	50	50	20
21	REMODELING	2002	12,000		20	200	200	200	21
22	QUARRY TILE INSTALLATION	2002	1,867		20	21	21	21	22
23	EXTERIOR FIXTURES	2002	1,731		20	43	43	43	23
24	AIR CONDITIONERS	2002	573		20	34	34	34	24
25	GENERATOR	2002	1,584		20	79	79	79	25
26	PIPES	2002	1,128		20	94	94	56	26
27	CHILLER	2002	960		20	72	72	48	27
28	SINK LINES	2002	1,687		20	98	98	84	28
29	FIRE PUMPS	2002	1,095		20	91	91	55	29
30	CALL SYSTEM	2002	990		20	33	33	50	30
31	OUTDOOR LAMPS	2002	1,366		20	46	46	68	31
32	PHONE CABLES	2002	525		20	13	13	28	32
33	FAN MOTORS	2002	1,100		20	9	9	55	33
34	TOTAL (lines 1 thru 33)		$ 3,029,611	$ 95,478		$ 106,623	$ 11,145	$ 1,694,237	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,029,611	$ 95,478		$ 106,623	$ 11,145	$ 1,694,237	1
2	PAINTING &DECORATING	2002	8,984		20	449	449	449	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,038,595	$ 95,478		$ 107,072	$ 11,594	$ 1,694,686	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 3,038,595	$ 95,478		$ 107,072	$ 11,594	$ 1,694,686	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,038,595	$ 95,478		$ 107,072	$ 11,594	$ 1,694,686	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 3,038,595	$ 95,478		$ 107,072	$ 11,594	$ 1,694,686	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,038,595	$ 95,478		$ 107,072	$ 11,594	$ 1,694,686	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 3,038,595	$ 95,478		$ 107,072	$ 11,594	$ 1,694,686	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,038,595	$ 95,478		$ 107,072	$ 11,594	$ 1,694,686	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 3,038,595	$ 95,478		$ 107,072	$ 11,594	$ 1,694,686	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,038,595	$ 95,478		$ 107,072	$ 11,594	$ 1,694,686	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 3,038,595	$ 95,478		$ 107,072	$ 11,594	$ 1,694,686	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,038,595	$ 95,478		$ 107,072	$ 11,594	$ 1,694,686	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 3,038,595	$ 95,478		$ 107,072	$ 11,594	$ 1,694,686	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,038,595	$ 95,478		$ 107,072	$ 11,594	$ 1,694,686	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocated from Boulevard Healthcare			2002	5,304	672	20	672		672	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,304	$ 672		$ 672	$	$ 672	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 658,254	$ 81,846	$ 70,061	$ (11,785)	10	$ 402,183	71
72	Current Year Purchases	42,836	4,467	4,897	430	10	4,897	72
73	Fully Depreciated Assets	544,595				10	544,595	73
74								74
75	TOTALS	$ 1,245,685	$ 86,313	$ 74,958	$ (11,355)		$ 951,675	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1982 FORD	1982	$ 14,556	$	$	$	5	$ 12,000	76
77		1986 VAN	1986	15,916				5	15,916	77
78		USED VAN	1988	3,000				5	3,000	78
79										79
80	TOTALS			$ 33,472	$	$	$		$ 30,916	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,673,752	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 181,791	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 182,030	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 239	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,677,277	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Building Addition	$ 245,140	92
93			93
94			94
95		$ 245,140	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Boulevard Healthcare Management Allocation				8,407			6
7	TOTAL				$ 8,407 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 10,750 Description: Copier $7634; Water Cooler $1622; Postage $1033; Alloc Boulevard $461
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 125,313	$		$ 125,313	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			42,915			42,915	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			510,376			510,376	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				174,139		174,139	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39 - 01		208,028					208,028	12
13	Other (specify): See Supplemental						239,835		239,835	13
14	TOTAL			$ 208,028		$ 678,604	$ 413,974		$ 1,300,606	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 3,727	$	1
2	Cash-Patient Deposits	60,689		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,286,856		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	108,596		6
7	Other Prepaid Expenses	232		7
8	Accounts Receivable (owners or related parties)	2,665,040		8
9	Other(specify): See Supplemental Schedule	240,669		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,365,809	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	486,000		13
14	Buildings, at Historical Cost	2,130,000		14
15	Leasehold Improvements, at Historical Cost	677,407		15
16	Equipment, at Historical Cost	1,346,173		16
17	Accumulated Depreciation (book methods)	(2,660,483)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	31,265		19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule	245,140		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,255,502	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,621,311	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,879,803	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	60,689		28
29	Short-Term Notes Payable	965,657		29
30	Accrued Salaries Payable	75,708		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,665		31
32	Accrued Real Estate Taxes(Sch.IX-B)	268,400		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	19,641		35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	26,597		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,304,160	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	70,477		39
40	Mortgage Payable	3,231,363		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,301,840	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,606,000	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,015,311	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,621,311	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,371,798	1	
2	Restatements (describe):		2	
3	**Rounding restatement**	4	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,371,802	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(256,491)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(100,000)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (356,491)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,015,311	24	*

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,723,545	1
2	Discounts and Allowances for all Levels	(1,784,929)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,938,616	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,519,758	6
7	Oxygen	38,108	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,557,866	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	286,053	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	55,326	19
20	Radiology and X-Ray	(999)	20
21	Other Medical Services	117,840	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 458,220	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	196,697	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 196,697	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,151,399	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,209,960	31
32	Health Care	2,963,083	32
33	General Administration	1,989,871	33
	B. Capital Expense		
34	Ownership	769,461	34
	C. Ancillary Expense		
35	Special Cost Centers	1,361,625	35
36	Provider Participation Fee	113,890	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,407,890	40
41	**Income before Income Taxes (line 30 minus line 40)****	(256,491)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (256,491)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not completed If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,933	2,075	$ 64,980	$ 31.31	1
2	Assistant Director of Nursing	1,777	1,917	51,183	26.70	2
3	Registered Nurses	29,093	35,785	717,833	20.06	3
4	Licensed Practical Nurses	15,081	16,321	309,517	18.96	4
5	Nurse Aides & Orderlies	79,340	86,475	811,317	9.38	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	3,522	3,876	208,028	53.66	7
8	Rehab/Therapy Aides	7,255	8,108	103,334	12.74	8
9	Activity Director	2,016	2,238	25,124	11.23	9
10	Activity Assistants	9,021	10,412	73,700	7.08	10
11	Social Service Workers	6,739	7,847	95,090	12.12	11
12	Dietician					12
13	Food Service Supervisor	1,990	2,198	36,735	16.72	13
14	Head Cook					14
15	Cook Helpers/Assistants	30,061	34,030	237,321	6.97	15
16	Dishwashers					16
17	Maintenance Workers	3,714	5,344	77,435	14.49	17
18	Housekeepers	22,841	26,687	178,744	6.70	18
19	Laundry	9,991	11,023	77,745	7.05	19
20	Administrator	2,104	2,230	89,259	40.03	20
21	Assistant Administrator	524	636	15,288	24.04	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,951	20,695	172,874	8.35	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,831	2,550	31,760	12.45	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	1,568	1,742	41,869	24.03	33
34	TOTAL (lines 1 - 33)	249,350	282,188	$ 3,419,136 *	$ 12.12	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	686	$ 26,461	01-03	35
36	Medical Director	268	26,780	09-03	36
37	Medical Records Consultant	88	3,696	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	187	7,480	10-03	39
40	Physical Therapy Consultant	150	7,139	10a-03	40
41	Occupational Therapy Consultant	104	1,755	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	2,423	11-03	44
45	Social Service Consultant	47	3,494	12-03	45
46	Other(specify)				46
47	Util Rev Consultant	428	12,604	10-03	47
48	Wound Care Consultant	66	3,300	10-03	48
49	TOTAL (lines 35 - 48)	2,072	$ 95,132		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	3,617	$ 186,243	10-03	50
51	Licensed Practical Nurses	5,404	214,133	10-03	51
52	Nurse Aides	8	304	10-03	52
53	TOTAL (lines 50 - 52)	9,029	$ 400,680		53

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
John Gutstein(1/1/02-1/9/02)	Administrator	0	$ 7,500
William Pfeiffer(1/15/02-12/31/02)	Administrator	0	81,759
Diane Schmidt	Asst Administrator	0	15,288
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 104,547

B. Administrative - Other

Description	Amount
David Meisels	$ 65,000
Quality Care Management Fees	263,856
Olympia Healthcare Management Fees	121,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 449,856
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 30,841
See attached	Computer Consulting	39,149
See attached	Legal	19,670
Personnel Planners	Unemployment Consultant	975
Econocare	Purchasing Consultant	175
Bridgemark	Compliance Consulting	2,679
Documentation Solutions	Collections (adj out pg 5)	175
Pension Resources	Pension service	630
Achieve Accreditation	JCAHO Consultant	27,500
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 121,794

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 65,785
Unemployment Compensation Insurance	44,462
FICA Taxes	244,022
Employee Health Insurance	153,834
Employee Meals	30,222
Illinois Municipal Retirement Fund (IMRF)*	
Holiday Expense	5,394
Head Tax	5,126
401k Expense	6,675
Employee Benefits	23,205
Pension Expense	14,461
Life Insurance	4,503
Disability	3,958
TOTAL (agree to Schedule V, line 22, col.8)	$ 601,646

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	32,805
Health Care Worker Background Check	
(Indicate # of checks performed)	
Promotional Advertising	31,785
Yellow Pages	2,518
Dues & Subscriptions	8,067
Licenses	10,911
Allocated from Quality Care	29
Allocated from Boulevard Healthcare	3,570
Less: Public Relations Expense	( )
Non-allowable advertising	(31,785)
Yellow page advertising	(2,518)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 55,382

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,869
Allocated from Boulevard Healthcare	735
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,604

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number CONTINENTAL CARE CENTER # 0022541 Report Period Beginning: 01/01/02 Ending: 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on LTC $11,293**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,060** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **113,880**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **30,222** Has any meal income been offset against related costs? **No** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **n/a**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% ln14**
d. Have vehicle usage logs been maintained? **n/a**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **n/a**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees